Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDICAL CENTER OF PLANO
10030 N MACARTHUR SUITE 100
IRVING TX 75063

Carrier's Austin Representative Box
54

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Date Received
FEBRUARY 15, 2012

MFDR Tracking Number
M4-12-2069-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken from the Table of Disputed Services: "Services/treatment was medically necessary and authorized. Dr. had pt. stay overnight since procedure was overnight to check for any complications."

Amount in Dispute: $6,803.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual preauthorized an outpatient admission for a rotator cuff repair on 2/8/11…The requestor then admitted the claimant for a one day inpatient stay. No rationale for the inpatient admission was provided to Texas Mutual with the initial bill or the request for reconsideration. For this reason Texas Mutual denied payment absent authorization. As of today, 2/28/12, Texas Mutual still does not know the reason for the admission other than a handwritten note on the Table of Disputed Services by anonymous stating, '…Dr. had pt. Stay overnight since overnight to check for any complications.' No other pertinent information was provided in the DWC-60 packet No payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 14, 2011 Through February 15, 2011	Inpatient Hospital Surgical Services	$6,803.34	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.

3. 28 Texas Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care.
4. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
5. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 7, 2011
   - REIMBURSEMENT MADE IN ACCORDANCE WITH RULE 134.404
   - CAC-B5 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED.
   - CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - 240 – PREAUTHORIZATION NOT OBTAINED.
   - 728 – THIS BILL WAS REVIEWED/DENIED IN ACCORDANCE WITH YOUR FIRST HEALTH CONTRACT. FOR QUESTIONS PLEASE CALL 1-800-937-6824.

   Explanation of benefits dated May 16, 2011
   - CAC-18 – DUPLICATE CLAIM/SERVICE.
   - CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - 224 – DUPLICATE CHARGE.
   - 240 – PREAUTHORIZATION NOT OBTAINED.

   Explanation of benefits dated June 7, 2011
   - REIMBURSEMENT MADE IN ACCORDANCE WITH RULE 134.404
   - CAC-B5 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED.
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - 240 – PREAUTHORIZATION NOT OBTAINED.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
   - 728 – THIS BILL WAS REVIEWED/DENIED IN ACCORDANCE WITH YOUR FIRST HEALTH CONTRACT. FOR QUESTIONS PLEASE CALL 1-800-937-6824.
   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
3. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 728 – "THIS BILL WAS REVIEWED/DENIED IN ACCORDANCE WITH YOUR FIRST HEALTH CONTRACT. FOR QUESTIONS PLEASE CALL 1-800-937-6824." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Per Texas Labor Code, Section §413.011(d) "the insurance carrier is not liable for those specified treatments and services requiring preauthorization unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or ordered by the commission." 28 Texas Administrative Code, Section §134.600(c)(1)(B) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) and (r)…only when the following situations occur…preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care." 28 Texas Administrative Code, Section §134.600(p)(1) requires preauthorization of "inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay.."
3. Review of the submitted documentation finds that the requestor did not submit documentation to support preauthorization was obtained for the inpatient hospital surgical services performed from February 14, 2011 through February 15, 2011. Therefore, no reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 6, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.